NORWICH FREE ACADEMY

Medical Center

Authorization for the Administration of Medication

Connecticut State Law requires a written medication order of an authorized prescriber (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist) (Podiatrist only for purposes of interscholastic and intramural events) and written permission from the parent/guardian for the nurse or in the absence of the school nurse, trained qualified personnel to administer medication. Medications must be provided to the school nurse in the original properly labeled container. Prescription medication must be in the original pharmacy labeled container. Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with board policy. Students may self-administer inhalers for asthma and cartridge injectors for medically-diagnosed allergies, with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Authorized Prescriber's Order

Name of the Student: _____ Date of Birth _____

Condition for which the medication is ordered: _____

Medication Name/Generic Name of Drug: _____ Controlled drug? Yes ☐ No €

Dose: _____ Method/Route: _____ Time of Administration: _____ If prn, frequency: _____

Medication shall be administered: Start Date: ____/_____/_____ End Date: _____/_____/____

Allergies: No ☐ Yes € (Specify) _____

Specific Instructions for Medication Administration: _____

Relevant side effects to be observed: _____

Plan of management for side effects: _____

Prescriber's Name/Title: _____ Phone Number: _____

Prescriber's Address: _____

Prescriber's authorization for self-administration: Yes € No €

Prescriber's Signature: _____ Date _____

Authorization of the Parent/Guardian for the Administration of Medication

I hereby request that the authorized prescribed medication order for my child be administered by school personnel. I will provide the school with no more than a three (3) month supply of medication, and understand that this medication will be disposed of according to school policy if not picked up by the parent/guardian or designated adult within one (1) week following the termination of the order, or the last day of school, whichever comes first.

I further agree and understand that it is the student's responsibility to be present as scheduled to receive the medication unless the student has any type of a plan that provides otherwise, and that Norwich Free Academy or its employees shall have no liability or responsibility for any medical problems experienced by the student as a result of the student's failure to be present to receive the medication at the appointed time and place, subject to such a plan.

I provide permission for the school nurse and prescriber to exchange information to ensure safe administration of the above prescribed medication and agree to execute any consent forms requested for purposes of permitting communication between Norwich Free Academy and the prescribing professional.

Parent/Guardian authorization for self-administration: YES ☐ NO ☐

Parent/Guardian Signature: _____ Date _____

Revised: 4/00, 1/01, 7/02, 4/08, 12/10, 5/11, 7/13, 3/16 See Also: NFA Policy for the Administration of Medication 5141.2